

MEDICAL BENEFIT BOOKLET

For

COUNTY EMPLOYEE BENEFITS CONSORTIUM OF
OHIO (CEBCO)

Blue Access PPO

Williams County – Gold Plan 2bb

Package 36

Effective Date: 1-1-2018

Administered By



Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling Member Services at the number on Your Identification Card.

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the health care plan (the Plan) offered by Your Employer. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Your Employer's Group Health Plan Administrator or call the Claims Administrator's Member Services Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

Your Employer has agreed to be subject to the terms and conditions of Anthem's provider agreements which may include precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by Your Employer to provide administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a network of health care Providers whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Ohio. Although Anthem is the Claims Administrator and is licensed in Ohio, You will have access to Providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

Verification of Benefits

Verification of benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Member Services with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 7:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL THE MEMBER SERVICES NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.

Identity Protection Services

Identity protection services are available with Your Employer's Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

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MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have rights and responsibilities when receiving health care. As Your health care partner, the Claims Administrator wants to make sure Your rights are respected while providing Your health benefits. That means giving You access to the Claims Administrator's network health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect the Claims Administrator to keep Your personal health information private by following the Claims Administrator's privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health Plan, and share Your feedback. This includes information on:
 - The Claims Administrator's company and services.
 - The Claims Administrator network of health care Providers.
 - Your rights and responsibilities.
 - The rules of Your health Plan.
 - The way Your health Plan works.
- Make a complaint or file an appeal about:
 - Your health Plan and any care You receive.
 - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care you're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give the Claims Administrator, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your ID card.

The Claims Administrator wants to provide high quality customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance

Anthem is committed to communicating with our Members about their health plan, regardless of their language. Anthem employs a language line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number on the back of Your Identification Card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Schedule of Benefits	Network	Out-of-Network
Calendar Year Deductible		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.		
All Covered Services are subject to the Deductible unless otherwise specified in this booklet.		
<p>Your Plan has an embedded Deductible which means:</p> <ul style="list-style-type: none"> • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Deductible amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Deductible amount. If You meet Your "Individual" Deductible amount, Your other family member's claims will still accumulate towards their own "Individual" Deductible and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Deductible or the entire "Family" Deductible is met. 		
The Network and Out-of-Network calendar Plan year Deductibles are separate and cannot be combined.		
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	80%	60%
Member Pays	20%	40%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		

Schedule of Benefits	Network	Out-of-Network
<p>Out-of-Pocket Maximum Per Calendar Year</p> <p>Includes Coinsurance and Copayments and the calendar year Deductible. Does NOT include Prescription Drug benefits, precertification penalties, charges in excess of the Maximum Allowed Amount, Non-Covered Services or Out-of-Network Human Organ and Tissue Transplant.</p>		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
<p>Your Plan has an embedded Out-of-Pocket which means:</p> <ul style="list-style-type: none"> • If You, the Subscriber, are the only person covered by this Plan, only the “Individual” amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the “Individual” and “Family” amounts apply. The “Family” Out-of-Pocket amounts can be satisfied by any combination of family members but You could satisfy Your own “Individual” Out-of-Pocket amount before the “Family” amount is met. You will never have to satisfy more than Your own ‘Individual” Out-of-Pocket amount. If You meet Your “Individual” amount, other family member’s claims will still accumulate towards their own “Individual” Out-of-Pocket and the overall “Family” amounts. This continues until Your other family members meet their own “Individual” Out-of-Pocket or the entire ‘Family” Out-of-Pocket is met. 		
<p>The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined.</p>		

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
<p>Allergy Care</p>		
Testing – Physician or Specialist Physician	20%	40%
Treatment – Physician Copayment/Coinsurance	20%	40%
Treatment – Specialist Physician Copayment/Coinsurance	20%	40%
Serum and allergy shots– Physician or Specialist Physician	\$5	40%
<p>Behavioral Health/Substance Abuse Care</p>		
Hospital Inpatient Services	20%	40%
Outpatient Services	\$20	40%
Physician Services (Home and Office Visits) Including Online Visits	\$20	40%
<p>Note: Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.</p>		
<p>Clinical Trials See Clinical Trials under Benefits section for further information.</p>	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
<p>Dental & Oral Surgery/TMJ Services</p>		
Accidental Injury to natural teeth Treatment must be completed within 12 months of the Injury)	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Oral Surgery/TMJ - Subject to Medical Necessity – excludes orthodontic treatment		

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
<p>Diagnostic Physician's Services</p>		
<p>Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:</p>		
Primary Care Physician Copayment	\$20	40%
Specialist Physician Copayment	\$40	40%
Diagnostic X-ray and Lab – office or independent lab	20%	40%
<p>Note: The office visit Copayment applies to the office visit procedure code, all other services billed for a Physician visit are subject to the calendar year Deductible and Coinsurance.</p>		
<p>Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.</p>		
<p>Emergency Room, Urgent Care, and Ambulance Services</p>		
Emergency room for an Emergency Medical Condition (Deductible does not apply.) (Copayment waived if admitted.)	\$200	\$200 (See note below)
Use of the emergency room for non-Emergency Medical Conditions	\$200	\$200
Urgent Care clinic visit for an Emergency Medical Condition Clinic visit (per visit) Copayment/Coinsurance	\$50	\$50 (See note below)
All other services	20%	
Ambulance Services (when Medically Necessary) Land/Air	20%	20% (See note below)
<p>Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.</p>		

Benefits	Network	Out-of-Network
Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Eye Care		
Office visit – medical eye care exams (treatment of disease or Injury to the eye)		
Primary Care Physician Copayment/Coinsurance	\$20	40%
Specialist Physician Copayment/Coinsurance	\$40	40%
Treatment other than office visit	20%	40%
Hearing Care		
Office visit – Audiometric exam/hearing evaluation test		
Primary Care Physician Copayment/Coinsurance	\$20	40%
Specialist Physician Copayment/Coinsurance	\$40	40%
Hearing devices/hearing aids	Not Covered	Not Covered
Home Health Care Services	20%	40%
Maximum Home Care visits (does not apply to Private Duty Nursing benefit)	90 visits per calendar year combined Network and Out-of-Network	
Private Duty Nursing	82 visits per calendar year, 164 visits per lifetime, combined Network and Out-of-Network	
Hospice Care Services	20%	20%
Hospital Inpatient Services – Precertification Required		
Room and board (Semiprivate or ICU/CCU)	20%	40%
Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), etc.)	20%	40%
<ul style="list-style-type: none"> Inpatient Physical Therapy – limited to 60 days per calendar year, combined Network and Out-of-Network 		
Pre-Admission testing	20%	40%

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
Physician Services:		
▶ Surgeon	20%	40%
▶ Anesthesiologist	20%	40%
▶ Radiologist	20%	40%
▶ Pathologist	20%	40%
<p>Note: *Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges.</p>		
Maternity Care & Other Reproductive Services		
Physician's office: Global care (includes pre-and post-natal, delivery)		
Primary Care Physician (includes obstetrician and gynecologist) Coinsurance	20%	40%
Specialist Physician Coinsurance	20%	40%
Midwife	20%	40%
Physician Hospital/Birthing Center Services (Precertification required)		
Physician's services	20%	40%
Newborn nursery services (well baby care)	Covered at 100% (not subject to Deductible)	40%
Circumcision	20%	40%
<p>Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified</p>		

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
<p>Infertility Services</p>		
<p>Limited Coverage Diagnostic Services and Limited Treatment</p> <p>(Non-Covered Services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.)</p>	20%	40%
<p>Sterilization Services (Precertification required for Inpatient procedures)</p>		
<p>Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in Benefits for further details.</p>		
Vasectomy	20%	40%
<p>Medical Supplies and Equipment</p>		
Medical Supplies	20%	40%
Durable Medical Equipment	20%	40%
Orthotics Foot and shoe	20%	40%
Prosthetic Appliances (external)	20%	40%
<p>Nutritional Counseling for Diabetes</p>	Covered at 100%	40%
<p>Nutritional Counseling for Eating Disorders</p>	Covered at 100%	40%
<p>Outpatient Hospital/Facility Services</p>		
Outpatient facility	20%	40%
Lab and x-ray services	20%	40%
<p>Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)</p>	20%	40%

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
Physician Services (Home and Office Visits)		
Primary Care Physician Copayment (per visit)	\$20	40%
Specialist Physician Copayment (per visit)	\$40	40%
Office Surgery	\$20/\$40	40%
Online Visits (Other than Behavioral Health & Substance Abuse; see Behavioral Health/Substance Abuse Care section for further details)	Covered at 100%	40%
Prescription Injectables/Prescription Drugs Dispensed in the Physician's Office	\$20/\$40	40%
Preventive Services	Covered at 100%	40%
Skilled Nursing Facility	20%	40%
Maximum days	90 days per calendar year combined Network and Out-of network.	
Surgical Services	20%	40%
Bariatric Surgery	20%	Not Covered
<p>Blue Distinction Bariatric Services Benefit: This benefit description applies to the Bariatric surgery, the pre-determination of eligibility by the Blue Distinction (BD) Bariatric Specialty Care Management unit, travel to a BD Designated Center of Excellence (COE) provider associated with the surgery event, and the after care provided by the BD Bariatric Specialty Care Management unit only.</p> <p>Designated BD Bariatric COE: For the Covered Bariatric Procedure, You will pay 20% of the Maximum Allowable Amount. Prior to and after the Covered Bariatric Procedure, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.</p> <p>Prior to and after the Covered Bariatric Procedure, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.</p> <p>Out of Network Bariatric provider: There is NO benefit</p>		

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
<p>Blue Distinction Cardiac Surgery Benefit</p>		
<p>Designated BDC+ Provider for Cardiac Procedures</p>	<p>Designated BDC Provider for Cardiac procedures or PAR (Network) Cardiac Provider (non-BDC+/BD Provider)</p>	<p>Non-PAR (Out-of-Network) Cardiac Provider</p>
<p>For the Covered Cardiac Procedure, You will pay 10% of the Maximum Allowed Amount when using a designated BDC+ Provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit.</p>	<p>For the Covered Cardiac Procedure, You will pay 20% of the Maximum Allowed Amount when using a designated BDC/PAR Provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit.</p>	<p>For the Covered Cardiac Procedure, You will pay 40% of the Maximum Allowed Amount when using a non-PAR, Out-of-Network Provider. As the Provider is non-PAR (Out-of-Network) You WILL be responsible for amounts that exceed the Maximum Allowed Amount (You WILL be required to pay any amounts due to Providers after Your health plan benefits have been applied).</p>
<p>Deductibles</p>		
<p>Normal Deductibles apply.</p>	<p>Normal Deductibles apply.</p>	<p>Out-of-Network Deductibles will apply.</p>
<p>Blue Distinction Orthopedic Surgery Benefit</p>		
<p>Designated BDC+ Provider for Knee/Hip Replacements & Spine Surgery Procedures</p>	<p>Designated BDC Provider or PAR (Network) Cardiac Provider (non-BDC+/BD Provider)for Knee/Hip Replacements & Spine Surgery procedures</p>	<p>Non-PAR (Out-of-Network) Orthopedic Provider</p>
<p>Benefit Limits for Covered Orthopedic Procedure:</p>		
<p>For the Covered Orthopedic Procedure, You will pay 10% of the Maximum Allowed Amount when using a designated BDC+ Provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is</p>	<p>For the Covered Orthopedic Procedure, You will pay 20% of the Maximum Allowed Amount when using a designated BDC/PAR Provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is</p>	<p>For the Covered Orthopedic Procedure, You will pay 40% of the Maximum Allowed Amount when using a non-PAR, Out-of-Network Provider. As the Provider is non-PAR (Out-of-Network) You WILL be responsible for amounts that exceed the Maximum Allowed Amount (You WILL be required to</p>

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
<p>NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit.</p>	<p>NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit.</p>	<p>pay any amounts due to Providers after Your health plan benefits have been applied).</p>
<p>Deductibles</p>		
<p>Normal Deductibles apply.</p>	<p>Normal Deductibles apply.</p>	<p>Out-of-Network Deductibles will apply.</p>
<p>Therapy Services (Outpatient)</p>		
<p>Physical Therapy - office visit copayment applies if services are performed in an office setting</p>	<p>20%</p>	<p>40%</p>
<p>Occupational Therapy -office visit copayment applies if services are performed in an office setting</p>	<p>20%</p>	<p>40%</p>
<p>Speech Therapy - office visit copayment applies if services are performed in an office setting</p>	<p>20%</p>	<p>40%</p>
<p>Cardiac Rehabilitation</p>	<p>20%</p>	<p>40%</p>
<p>Manipulation Therapy - office visit copayment applies if services are performed in an office setting</p>	<p>20%</p>	<p>40%</p>
<p>Radiation Therapy - office visit copayment applies if services are performed in an office setting</p>	<p>20%</p>	<p>40%</p>
<p>Chemotherapy – office visit copayment applies if services are performed in an office setting</p>	<p>20%</p>	<p>40%</p>
<p>Respiratory Therapy - office visit copayment applies if services are performed in an office setting</p>	<p>20%</p>	<p>40%</p>
<p>Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.</p>		
<p>Benefits for Physical Therapy are limited to 30 visits per calendar year, combined Network and Out-of-Network</p>		
<p>Benefits for Occupational Therapy are limited to 30 visits per calendar year, combined Network and Out-of-Network</p>		
<p>Benefits for Speech Therapy are limited to 20 visits per calendar year, combined Network and Out-of-Network</p>		
<p>Benefits for Manipulation Therapy are limited to 12 visits per calendar year, combined Network and Out-of-Network</p>		

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
<p>Transplants</p>		
<p>Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy.</p> <p>The Center of Excellence requirements do not apply to Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.</p> <p>Note: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.)</p>	<p>Center of Excellence/Network Transplant Provider</p>	<p>Out-of-Network Transplant Provider</p>
<p>Transplant Benefit Period</p>	<p>Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Member Services number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)</p>	<p>Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.</p>

Benefits	Network	Out-of-Network
<p>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</p>		
<p>Covered Transplant Procedure during the Transplant Benefit Period</p>	<p>Covered at 100%</p>	<p>50%</p>
<p>Care coordinated through a Network Transplant Provider/ Center of Excellence – not subject to Deductible When performed by Out-of-Network Transplant Provider (subject to Deductible, does not apply to the Out of Pocket Maximum). You are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.</p>		
<p>Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)</p>	<p>Covered at 100%</p>	<p>50%</p>
<p>Includes unrelated donor search up to \$30,000 per transplant.</p>		
<p>Eligible Travel and Lodging –</p>	<p>Covered at 100%</p>	<p>50%</p>
<p>Limited to \$10,000 per transplant maximum combined Network and Out-of-Network subject to Claims Administrator's approval.</p>		

TOTAL HEALTH AND WELLNESS SOLUTION

ComplexCare

The ComplexCare program reaches out to You if You are at risk for frequent and high levels of medical care in order to offer support and assistance in managing Your health care needs. ComplexCare empowers You for self-care of Your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with You and Your Physician to offer:

- Personalized attention, goal planning, health and lifestyle coaching.
- Strategies to promote self-management skills and medication adherence.
- Resources to answer health-related questions for specific treatments.
- Access to other essential health care management programs.
- Coordination of care between multiple Providers and services.

The program helps You effectively manage Your health to achieve improved health status and quality of life, as well as decreased use of acute medical services.

ConditionCare Programs

ConditionCare programs help maximize Your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).

You will receive:

- 24/7 phone access to a nurse coach who can answer Your questions and give You up-to-date information about Your condition.
- A health review and follow-up calls if You need them.
- Tips on prevention and lifestyle choices to help You improve Your quality of life.

Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches supported by pharmacists, registered dietitians, social workers and medical directors. You will receive:

- 24/7 phone access to a nurse coach who can talk with You about Your pregnancy and answer Your questions.
- *Your Pregnancy Week by Week*, a book to show You what changes You can expect for You and Your baby over the next nine months.
- Useful tools to help You, Your Physician and Your Future Moms nurse coach track Your pregnancy and spot possible risks.

24/7 NurseLine

You may have emergencies or questions for nurses around-the-clock. 24/7 NurseLine provides You with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, You can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer You to programs and tools appropriate to Your condition.
- Bilingual RNs, language line and hearing impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison control and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.]

Value-Added Programs

The Administrator, on behalf of CEBCO, may offer health or fitness related programs to the Plan's Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under the Plan and could be discontinued at any time. The Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive

Voluntary Clinical Quality Programs

The Administrator may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) within a specific timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under this Plan. These programs are not guaranteed and could be discontinued at any time. The Administrator will give you the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If You receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to You. For additional guidance, please consult Your tax advisor.)

Anthem Imaging Shopper

If You need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where You go to receive the service. Sometimes the differences are significant – anywhere from \$300 to \$3000 – but a higher price doesn't guarantee higher quality. If Your benefit plan requires You to pay a portion of this cost (like a Deductible or Coinsurance) where You go can make a very big difference to Your wallet.

How the program works

- Your doctor lets Anthem know You will have one of these procedures.
- Anthem will check to see if the Provider who will perform the procedure offers a low cost for the service.
- If not, Anthem will call You to give You other choices nearby.
- You choose the Provider that best meets Your needs, whether it's the one Your doctor suggested or one Anthem tells You about. It's completely up to You!

ELIGIBILITY AND ENROLLMENT

Benefits payable under the Plan are available to you because of your employment with or membership with or retirement from CEBCO.

In order for you to participate in the Plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods, and Actively At Work standards. The specific time periods and other standards for participation in the Plan are determined by CEBCO, or state and/or federal law. Eligibility requirements are described in general terms below.

For more specific eligibility information, you should see your Human Resources or Benefits department.

Eligibility

Unless CEBCO notifies you otherwise, the following eligibility rules apply:

Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be an employee of a CEBCO member county or entity who is entitled to participate in the benefit plan arranged by CEBCO, who has satisfied any probationary or waiting period established by CEBCO who is Actively At Work, and meets the Plan's eligibility criteria.

Dependents

To be eligible to enroll under the Plan as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by CEBCO and be:

- The Subscriber's spouse. For information on spousal eligibility please contact CEBCO.
- The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children. The event date for an adopted child is the earlier of the date of adoption or date of placement for adoption. Placement for adoption means the assumption and retention of legal obligation for total and partial support for a child in anticipation of adoption of such child (included are natural children, adopted children and children who CEBCO has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law).
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law

All enrolled eligible, children may continue to be covered until the end of the month they attain age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period they would become ineligible for benefits. The Plan must certify the Dependent's eligibility. CEBCO must be informed of the Dependent's eligibility for continuation of benefits under the Plan within 31 days after the Dependent would normally become ineligible. You must notify the Plan if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

CEBCO may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's benefits under the Plan.

To enroll children under the Plan, the Subscriber may be required to complete and provide a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under the Plan.

College Student Medical Leave

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The Plan must receive written certification from the child's Physician confirming the serious illness or injury and the Medical Necessity of the leave or change in status.

Out of Service Area Dependent Child Coverage

Benefits for Covered Services will be provided for enrolled Dependent children who reside outside of the Service Area due to such children attending an out of Service Area educational institution or residing with the Subscriber's former spouse. Payment of benefits for these additional Covered Services is limited to the Maximum Allowable Amount. Payment is subject to any Copayment or Coinsurance. You may be responsible for any amount in excess of the Maximum Allowable Amount.

Enrollment

Persons who are eligible to enroll as Members must enroll at the time agreed upon by CEBCO. Otherwise, they may be subject to the terms of Late Enrollment or Special Enrollment as set forth in this Benefit Booklet.

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage through CEBCO. That enrollment must be received by the date established by CEBCO, and agreed to by the Administrator, for Initial Enrollment. If the Administrator does not receive the Initial Enrollment by this date, the Eligible Person can only enroll for benefits during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

If a dependent of the Eligible Person qualifies as a Dependent under the Plan at the time of the Eligible Person's Initial Enrollment, but does not enroll, that person can only enroll for benefits during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

Coverage will be effective based on the waiting period chosen by CEBCO, and will not exceed 90 days.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on Eligible Dependents.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for illness or injury for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days only if the Subscriber submits through CEBCO, a change to add the child under the Subscriber's Plan. The change must be submitted within 31 days after the birth of the child. Failure to notify the Plan during this 31 day period will result in no benefits for the newborn and the newborn can only enroll for benefits during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

A child will be considered adopted from the earlier of (1) the moment of placement in your home or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Legal Guardianship

If a subscriber or the Subscriber's spouse becomes the legal guardian for a child, an application must be submitted within 31 days of the date legal guardianship is approved by the court or the child will be treated as a Late Enrollee. Coverage will be effective on the date the court approves legal guardianship if CEBCO receives an application within 31 days of that qualifying event.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Benefit Booklet, the Plan will permit your child to enroll at any time without regard to any open enrollment limits and will provide the benefits of this Benefit Booklet in accordance with the order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Benefit Booklet will be paid, at our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Plan will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Plan directly.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your other coverage ends (or within 60 days after Medicaid coverage ends) after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). . In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If the Administrator receives an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If the Plan receives an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, the Plan will not be able to enroll that person until the Employer's next Open Enrollment.

Application forms are available from CEBCO.

Late Enrollment

An Eligible Person or Dependent who did not request enrollment for coverage with the Plan during the initial enrollment period, as a newly eligible person, or a Special Enrollment period during which the individual was entitled to enroll is considered a Late Enrollee and not eligible to enroll for coverage with the Plan until the next open enrollment period.

Notice of Changes

The Subscriber is responsible for notifying CEBCO of any changes which will affect his or her eligibility or that of Dependents for services or benefits under the Plan. CEBCO must be notified of any changes as

soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. Failure to notify CEBCO of persons no longer eligible for services will not obligate the Plan to pay for such services. Acceptance of payments from CEBCO for persons no longer eligible for services will not obligate the Plan to pay for such services.

All notifications by CEBCO must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to single Coverage. CEBCO must be notified when a Member becomes eligible for Medicare.

If CEBCO determines that the Member is not eligible for benefits, CEBCO may cancel that Member's coverage immediately. The termination date shall be retroactive to the date the person was no longer eligible. CEBCO has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's benefits.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender or age.

Effective Date of Coverage

For more specific information concerning your Effective Date, you should see your Human Resources or benefits department.

Continuous Coverage

If CEBCO moves from one Anthem Blue Cross Blue Shield plan to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately prior to enrolling in this product with no break in coverage, then you may receive credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by CEBCO. Any maximums, including the Lifetime Maximum, when applicable, will be carried over and charged against the maximums under this Benefit Booklet.

If CEBCO offers more than one Anthem product, and you change from one Anthem product to another with no break in coverage, you will receive credit for any accrued Deductible and, if applicable, Out of Pocket amounts.

If CEBCO offers coverage through other products or carriers in addition to Anthem's, and you change products or carriers to enroll in this Anthem product with no break in coverage, you will receive credit for any accrued Deductible, Out of Pocket, and any maximums amounts.

THIS SECTION DOES NOT APPLY TO YOU IF YOU:

- change from an individual Anthem Blue Cross Blue Shield policy to a group Anthem Blue Cross Blue Shield plan;
- change employers and both have Anthem Blue Cross Blue Shield coverage; or
- are a new Member of CEBCO who joins CEBCO after CEBCO's initial enrollment with Anthem.

Statements and Forms

Subscribers or applicants for coverage shall complete and submit to the Administrator applications, medical review questionnaires, or other forms or statements the Administrator, on behalf of CEBCO, may reasonably request. Subscribers or applicants for coverage represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for coverage understand that all

rights to benefits under the Plan are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of benefits as provided in the Termination section.

Delivery of Documents

The Administrator, on behalf of CEBCO, will provide an Identification Card for each Member and a Benefit Booklet for each Subscriber.
h status.

HOW YOUR PLAN WORKS

Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the “Definitions” Section.

Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Network Services

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for You. Referrals are never needed to visit a Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them You are an Anthem Member,
- Have Your Member Identification Card handy. The Doctor’s office may ask You for Your group or Member ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Member Identification Card with You.

For services from Network Providers:

1. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by Your In-Network Provider(s) for any non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (See the **Health Care Management – Precertification** section for further details.)

Please read the **Claims Payment** section for additional information on Authorized Services.

After Hours Care

If You need care after normal business hours, Your Doctor may have several options for You. You should call Your Doctor’s office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

- The Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see "Health Care Management – Precertification" for more details.)

How to Find a Provider in the Network

There are three ways You can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with Your Doctor or Provider.

If You need details about a Provider's license or training, or help choosing a Doctor who is right for You, call the Member Services number on the back of Your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard," which provides services to You when You are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the **Claims Payment** section.

Copayment

Certain Network services may be subject to a Copayment amount which is a flat-dollar amount You will be charged at the time services are rendered.

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Schedule of Benefits**. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the **calendar year Deductible** and payable at the **percentage payable** in the **Schedule of Benefits**.

Calendar Year Deductible

Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits**.

HEALTH CARE MANAGEMENT - PRECERTIFICATION

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

If You have any questions regarding the information contained in this section, You may call the Member Services telephone number on Your Identification Card or visit www.anthem.com.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides Your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an Exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews:

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
- **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Benefit Booklet.

For admissions following Emergency Care, You, Your authorized representative or Doctor must tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Continued Stay/Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator. An example of a type of post-service review is a retrospective post-claim review. For retrospective reviews if you send a written request, the Plan will permit a retrospective review for a claim that is submitted where prior authorization was required but not obtained if the service in question meets all of the following:
 - a. The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
 - b. The new service was not known to be needed at the time the original prior authorized service was performed.
 - c. The need for the new service was revealed at the time the original authorized service was performed.

Once the Plan receives the written request and all necessary information the Administrator will review the claim for coverage and Medical Necessity. The Plan will not deny a claim for the new service based solely on the fact that the Administrator did not receive a prior authorization approval for the new service in question.

The following list is not all inclusive and is subject to change; please call the Member Services telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

Inpatient Admission:

- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother's stay)
- Emergency Admissions (requires Plan notification no later than 2 business days after admission)

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance (excludes 911 initiated emergency transport)
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric surgery
- Bone-Anchored Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction , Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants

- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
 - ▶ Diagnosis of Sleep Disorders
- DME/Prosthetics
 - ▶ Bone Growth Stimulator: Electrical or Ultrasound
 - ▶ Communication Assisting / Speech Generating Devices
 - ▶ External (Portable) Continuous Insulin Infusion Pump
 - ▶ Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
 - ▶ Microprocessor Controlled Lower Limb Prosthesis
 - ▶ Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
 - ▶ Pneumatic Pressure Device with Calibrated Pressure
 - ▶ Power Wheeled Mobility Devices
 - ▶ Prosthetics: Electronic or externally powered and select other prosthetics
 - ▶ Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Gender Reassignment Surgery
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Genetic Testing for Cancer Susceptibility
- Implantable or Wearable Cardioverter-Defibrillator
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea

- Occipital nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Percutaneous Spinal Procedures
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
- Plastic/Reconstructive surgeries:
 - ▶ Abdominoplasty ,Panniculectomy, Diastasis Recti Repair
 - ▶ Blepharoplasty
 - ▶ Brachioplasty
 - ▶ Buttock/Thigh Lift
 - ▶ Chin Implant, Mentoplasty, Osteoplasty Mandible
 - ▶ Insertion/Injection of Prosthetic Material Collagen Implants
 - ▶ Liposuction/Lipectomy
 - ▶ Procedures Performed on Male or Female Genitalia
 - ▶ Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
 - ▶ Procedures Performed on the Trunk and Groin
 - ▶ Repair of Pectus Excavatum / Carinatum
 - ▶ Rhinoplasty
 - ▶ Skin-Related Procedures
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing
- Radiation therapy
 - ▶ Intensity Modulated Radiation Therapy (IMRT)
 - ▶ Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Migraine Headaches
- Thoracoscopy for Treatment of Hyperhidrosis

- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventricular Device
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- All Outpatient services for the following:
 - ▶ Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
 - ▶ Donor Leukocyte Infusion

Out of Network Referrals:

Out of Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or Medical Necessity.)

Mental Health/Substance Abuse (MHSA):

Pre-certification Required

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care
- ABA- Applied Behavioral Analysis

The following services do not require precertification, but are recommended for pre-determination of Medical Necessity due to the existence of post service claim review criteria and/or the potential cost of services to the Member if denied by for lack of Medical Necessity: Procedures, equipment.

Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification. However, You may request a Precertification or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (IN, KY, OH).	Provider	<ul style="list-style-type: none"> The Provider must get Precertification when required
Out-of- Network/ Non-Participating	Member	<ul style="list-style-type: none"> Member must get Precertification when required. (Call Member Services.) Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.
Blue Card Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed,	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"> Member must get Precertification when required. (Call Member Services.) Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. Blue Card Providers must obtain precertification for all Inpatient Admissions.
<p>NOTE: For an Emergency Care admission, precertification is not required. However, You, Your authorized representative or Doctor must tell the Claims Administrator within 2 business days of admission or as soon as possible within a reasonable period of time.</p>		

How Decisions are Made

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with the Plan's decision under this section of Your benefits, please refer to the **Your Right To Appeal** section to see what rights may be available to You.

Decision and Notice Requirements

Timeframes and requirements listed are based on Federal regulations. If you reside and/or receive services in a state other than the state where your contract was issued other state-specific Health Care Management requirements may apply. You may call the telephone number on the back of your membership card for additional information.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Concurrent/Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Concurrent/Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Concurrent/Continued Stay Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If additional information is needed to make a decision, the Claims Administrator will notify the requesting Provider of the specific information necessary to complete the review. If the Claims Administrator does not receive the specific information requested by the required timeframe, a decision will be made based upon the information in the Claims Administrator's possession.

The Claims Administrator will notify you and your Provider of a decision in accordance with federal regulations. Notification may be given by one or more of the following methods: verbal, written, and/or electronic.

Once a pre-service review is approved, it will not be retroactively denied, except in cases of fraudulent or materially incorrect information, when all of the following are met:

- The Provider submits a prior authorization request to the Claims Administrator for a health care service, drug, or device;
- The Plan approves the prior authorization request after determining that all of the following are true:
 1. The patient is eligible under this Plan.
 2. The health care service, drug, or device is covered under this Plan.
 3. The health care service, drug, or device meets our standards for Medical Necessity and prior authorization.
- The Provider renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the Provider's contract with the Claims Administrator;
- On the date the health care practitioner renders the prior approved health care service, drug, or device, all of the following are true:
 1. The patient is eligible under this Plan.
 2. The patient's condition or circumstances related to their care has not changed.
 3. The Provider submits an accurate claim that matches the information submitted by the Provider in the approved prior authorization request.

- If the Provider submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the Provider in the approved prior authorization request, upon receiving a denial of services from the Plan, the Provider may resubmit the claim with the information that matches the information included in the approved prior authorization.

Electronic Submission of Pre-service reviews

If the request for a Pre-service Review of a health care service, device, or drug is submitted to the Claims Administrator electronically from your Provider, the Plan will respond:

- Within forty-eight (48) hours of the time the request is received if it's for Urgent Care Services;
- Within ten (10) calendar days of the time the request is received if it's for non-Emergency or non-Urgent Care Services.

The Plan's response will state if the request is approved or denied. If denied, the Plan will provide the specific reason for the denial. If incomplete, the Plan will indicate the specific additional information that is required to process the request. If the Claims Administrator requests additional information required to process the request, your Provider must provide an electronic receipt to the Claims Administrator acknowledging that the request for additional information was received.

Please note that the appeals procedures under the **Your Right to Appeal** section of this Benefit Booklet are also available under this option.

For purposes of this section only, Urgent Care Services means medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of a Pre service Review request as outlined in the **Health Care Management - Precertification** section of this Plan.

This section does not apply to Emergency services.

Important Information

From time to time certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if in the Plan's sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because a process, Provider or Claim is exempted from the standards which otherwise would apply, it does not mean that this will occur in the future, or will do so in the future for any other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a provider arrangement by contacting the Member Services number on the back of Your Identification Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

The Claims Administrator's individual health plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to You. These programs are provided by, or on behalf of and at the request of, Your health plan Case Management staff. These Case Management programs are separate from any Covered Services You are receiving.

If You meet program criteria and agree to take part, the Claims Administrator will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet Your needs. This may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or Injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if at the Claims Administrator's discretion the alternate or extended benefit is in the best interest of You and the Plan and You or Your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or Your authorized representative in writing.

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

Ambulance Service

Medically Necessary Ambulance Services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, You are taken:
 - From Your home, the scene of an accident or Medical Emergency to a Hospital;
 - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, You are taken:
 - From the scene of an accident or Medical Emergency to a Hospital;
 - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or Injury by medical professionals from an ambulance service, even if You are not taken to a Facility.

Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Physician are not a Covered Service.

Other non-covered Ambulance Services include, but are not limited to, trips to:

- a Physician's office or clinic; or
- a morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if You are taken to a Physician's office or Your home.

Hospital to Hospital Transport

If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger Your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. **Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.**

Assistant Surgery

Services rendered by an assistant surgeon are covered based on Medical Necessity.

Behavioral Health Care and Substance Abuse Treatment

See the **Schedule of Benefits** for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
 - observation and assessment by a psychiatrist weekly or more often; and
 - rehabilitation, therapy, and education.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs
- **Online Visits** when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist;
- Psychologist;
- Licensed Clinical Social Worker (L.C.S.W.);

- mental health clinical nurse specialist;
- Licensed Marriage and Family Therapist (L.M.F.T.);
- Licensed Professional Counselor (L.P.C); or
- any agency licensed by the state to give these services, when they have to be covered by law.

Breast Cancer Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Cardiac Rehabilitation

Covered Services are provided as outlined in the **Schedule of Benefits**.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to You as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize Your benefits.

Routine patient care costs include items, services, and drugs provided to You in connection with an approved clinical trial that would otherwise be covered by this Plan.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be investigational as defined by this Plan. All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

1. The Experimental/Investigative item, device, or service; or
2. Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Please note that under Ohio state law, to qualify for coverage, you do not have to:

1. Have the reference of a participating health professional; or
2. Provide appropriate medical and scientific information.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals (the transfer of a patient from one Physician to another for treatment) are not consultations under this Plan.

Dental Services

Related to Accidental Injury

Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Treatment must be completed within the timeframe shown in the **Schedule of Benefits**.

Other Dental Services

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- the Member is under the age of five (5);
- the Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- the Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes

Equipment and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- it can stand repeated use;
- it is manufactured solely to serve a medical purpose;
- it is not merely for comfort or convenience;
- it is normally not useful to a person not ill or Injured;
- it is ordered by a Physician;
- the Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item; and
- it is related to the Member's physical disorder.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is Your responsibility.

Emergency Services

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care including a medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical or behavioral health examination and treatment as are required to Stabilize the patient.

Emergency Service care does not require any Prior Authorization from the Plan. Services provided for conditions that do not meet the definition of Emergency will not be covered for anyone over age 15.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:

- the amount negotiated with Network Providers for the Emergency service furnished;
- the amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- the amount that would be paid under Medicare for the Emergency Service.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the **Schedule of Benefits**.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

Habilitative Services

Benefits also include habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- services and/or supplies which are not included in the Home Health Care plan as described;
- services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse;
- any services for any period during which the Member is not under the continuing care of a Physician;
- convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member;
- any services or supplies not specifically listed as Covered Services;
- routine care and/or examination of a newborn child;
- dietician services;
- maintenance therapy;
- dialysis treatment; or
- purchase or rental of dialysis equipment.

Hospice Care Services

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- social services and counseling services from a licensed social worker;
- nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means Your Spouse, children, stepchildren, parents, brothers and sisters.

Your Physician and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Benefit Booklet.

Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

Human Organ and Tissue Transplant Services

Notification

To maximize Your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

Contact the Member Services telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or Benefit Booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Claims Administrator for specific Network Transplant Provider information for services received at, or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of Your Identification Card **and ask for the transplant coordinator**. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits**. Speech therapy is not covered when rendered for the treatment of Developmental Delay.

Maternity Care and Reproductive Health Services

Covered Services are provided for Network Maternity Care as stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

Abortion

Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Infertility Services

Your Plan also includes benefits for the diagnosis and treatment of Infertility. See the **Schedule of Benefits** for benefit limitations, Coinsurance and Copayment amounts.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Medical Care

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

Nutritional Counseling

Nutritional counseling related to the medical management of a disease state as stated in the **Schedule of Benefits**.

Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

Out-of-Network Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

Obesity

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan.

Online Visits

When available in Your area, Your coverage will include online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See **Schedule of Benefits** for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. For Behavioral Health

and Substance Abuse Online Visits, see the “Behavioral Health Care and Substance Abuse Treatment” section. Non-Covered Services include, but are not limited to communications used for:

- reporting normal lab or other test results;
- office appointment requests;
- billing, insurance coverage or payment questions;
- requests for referrals to Physicians outside of the online care panel;
- benefit precertification; and
- Physician to Physician consultation.

Oral Surgery

Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofascial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within the timeframes shown in the **Schedule of Benefits** after the accident.

Although this Plan covers certain oral surgeries as listed above, many oral surgeries (e.g. removal of wisdom teeth) are not covered. Covered Services also include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral/surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Other Covered Services

Your Plan provides Covered Services when the following services are Medically Necessary:

- chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- diagnostic x-ray and laboratory procedures;
- dressings, splints and casts when provided by a Physician;
- oxygen, blood and components, and administration;
- pacemakers and electrodes; or
- use of operating and treatment rooms and equipment.

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Hospital Services

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

Outpatient Surgery

Network Hospital outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under "Hospital Services".

Physical Therapy, Occupational Therapy, Manipulation Therapy

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when such services are necessitated by Developmental Delay.

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when You use a Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under Diagnostic services instead of this benefit, if the coverage does not fall within ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
 - a. breast cancer;
 - b. cervical cancer;
 - c. colorectal cancer;
 - d. high blood pressure;
 - e. Type 2 Diabetes Mellitus;
 - f. Cholesterol;
 - g. child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

- c. Gestational diabetes screening.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
- a. Counseling
 - b. Prescription Drugs
 - c. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.
- Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
- a. Aspirin
 - b. Folic acid supplement
 - c. Vitamin D supplement
 - d. Bowel preparations
- Please note that certain age and gender and quantity limitations apply.

You may call Member Services using the number on Your Identification Card for additional information about these services or view the Federal government's web sites, <http://www.healthcare.gov/center/regulations/prevention.html>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.)

Covered Services also include the following services required by state and federal law:

- Routine screening mammograms. The total benefit for a screening mammography under this Plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty per cent (130%) of the Medicare reimbursement rate in the state of Ohio for a screening mammography. If a Provider, Hospital, or other health care facility provides a service that is a component of the screening mammography and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital, or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for mammography constitutes full payment under this Certificate. No Provider, Hospital, or other health care facility shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio.
- Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test).
- Child health supervision services from the moment of birth until age nine. Child health supervision services mean periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Other Covered Services are:

- Routine hearing screenings
- Routine vision screenings

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic Injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: Coverage for reconstructive services does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Retail Health Clinic

Benefits are provided for Covered Services received at a Retail Health Clinic.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member’s residence.

Covered Services include:

- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- Physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician’s continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- a Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- no specific medical conditions exist that require care in a Skilled Nursing Facility; or
- the care rendered is for other than Skilled Convalescent Care.

Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

Blue Distinction Bariatric Surgery Benefit

Blue Distinction is a national designation program which recognizes hospitals that have demonstrated expertise in delivering quality specialty care for patients with highly complex medical needs.

Your Employer has implemented the following benefit requirements related to the use of designated Blue Distinction facilities.

Covered Bariatric Procedure(s). This benefit applies to the following Medically Necessary bariatric procedure(s) as determined by the Claims Administrator:

- Gastric banding
- Gastric stapling

Blue Distinction Cardiac Surgery Benefit

Blue Distinction is a national designation program which recognizes hospitals that have demonstrated expertise in delivering quality specialty care for patients with highly complex medical needs.

Your Employer has implemented the following benefit requirements related to the use of designated Blue Distinction facilities.

Covered Cardiac Procedure(s). This benefit applies to the following Medically Necessary cardiac procedure(s) as determined by the Claims Administrator:

- Coronary artery bypass graft
- Percutaneous coronary intervention

Blue Distinction Orthopedic Surgery Benefit

Blue Distinction is a national designation program which recognizes Hospitals that have demonstrated expertise in delivering quality specialty care for patients with highly complex medical needs.

Your Employer has implemented the following benefit requirements related to the use of designated Blue Distinction facilities.

Covered Orthopedic Procedures. This benefit only applies to Medically Necessary Knee/Hip Replacement or Spine Surgery Procedures as designated by the Claims Administrator restricted to the following procedures:

- Total knee replacement;
- Revision knee replacement;
- Total hip replacement;
- Revision hip replacement;
- Discectomy;

- Decompression;
- Primary spinal fusion; and,
- Revision spinal fusion.

Treatment of Accidental Injury in a Physician's Office

All outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider. Services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

Prescription Drugs Administered by a Medical Provider

This Plan covers Prescription Drugs including Specialty Drugs, that must be administered to You as part of a Doctor's visit, home care visit, or at an outpatient facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to You in a medical setting. Benefits for Drugs You inject or get from a retail pharmacy (i.e. self-administered Drugs) are not covered.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Doctor may be asked to give more details before the Plan decides if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated.
- Use of an Anthem Prescription Drug List (a formulary developed by the Claims Administrator which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.
- Coverage of an opioid analgesic prescribed for the treatment of chronic pain, except when the drug is prescribed to you under one of the following circumstances:
 1. If you are a hospice patient in a hospice care program;
 2. If you are diagnosed with a terminal condition but are not a hospice patient in a hospice care program;
 3. If you have cancer or another condition associated with your cancer or history of cancer.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will give the results of the Plan's decision to both You and Your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section **Health Care Management - Precertification** for more details.

If precertification is denied You have the right to file an appeal as outlined in the **Your Right To Appeal** section of this Benefit Booklet.

For a prior approval related to a chronic condition, the Plan will honor a prior authorization approval for an approved drug for the lesser of the following from the date of the approval:

- Twelve months;
- the last day of your eligibility under this Plan.

For purposes of this section “chronic condition” means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

The twelve-month approval is no longer valid and automatically terminates if there are changes to Federal or state laws or Federal regulatory guidance or compliance information states that the drug in question is no longer approved or safe for the intended purpose.

- Prior Authorization may be required for an opioid analgesic prescribed for the treatment of chronic pain, except when the drug is prescribed to you under one of the following circumstances:
 1. If you are a hospice patient in a hospice care program;
 2. If you are diagnosed with a terminal condition but are not a hospice patient in a hospice care program;
 3. If you have cancer or another condition associated with your cancer or history of cancer.

Once a prior authorization review is approved, it will not be retroactively denied except in cases of fraudulent or materially incorrect information, or as otherwise provided under applicable state law.

Designated Pharmacy Provider

The Plan in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider’s office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider’s office.

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Plan reserves the right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. The Plan may from time to time, change with or without advance notice, the Designated Pharmacy Provider

for a Drug, if in the Plan's discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at www.anthem.com.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed Drugs. The Claims Administrator may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of Your Identification Card.

LIMITATIONS AND EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide benefits for procedures, equipment, services, supplies or charges:

1. Which the Administrator, on behalf of CEBCO, determines are not Medically Necessary or do not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not licensed by law to provide Covered Services, as defined in this Benefit Booklet. Examples may include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of CEBCO.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities unless otherwise required by law or regulation.
9. For court ordered testing or care unless Medically Necessary.
10. For which you have no legal obligation to pay in the absence of this or like coverage.
11. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
12. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
13. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

14. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
15. For missed or canceled appointments.
16. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Administrator, on behalf of CEBCO, or specifically stated as a Covered Service.
17. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if a Member had applied for Parts A and/or B, except, as specified elsewhere in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.
18. Charges in excess of the Plan's Maximum Allowable Amounts.
19. Incurred prior to your Effective Date.
20. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
21. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by the Administrator, on behalf of CEBCO, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
22. Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
23. For Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional.
24. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
 - cleaning and soaking the feet.
 - applying skin creams in order to maintain skin tone.
 - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
25. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
26. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or

related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.

27. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
28. For Dental implants.
29. For Dental braces.
30. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
 - transplant preparation.
 - initiation of immunosuppressives.
 - direct treatment of acute traumatic injury, cancer or cleft palate.
31. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
32. Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in the "Covered Services" section. Weight loss programs for medical reasons are also excluded.
33. For marital counseling.
34. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
35. For vision orthoptic training.
36. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Benefit Booklet.
37. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
38. For reversal of sterilization.
39. For diagnostic testing or treatment related to infertility.
40. For personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.

41. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Administrator, on behalf of CEBCO.
42. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
43. For expenses incurred at a health spa or similar facility.
44. For self-help training and other forms of non-medical self care, except as otherwise provided herein.
45. For examinations relating to research screenings.
46. For stand-by charges of a Physician.
47. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
48. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.
49. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
50. For Manipulation Therapy services rendered in the home as part of Home Care Services.
51. Any new FDA Approved Drug Product or Technology (**including but not limited to medications, medical supplies, or devices**) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
52. Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Prescription drugs for sexual or erectile dysfunction may be covered with your prescription drug carrier.
53. For Outpatient Prescription Legend Drugs or Mail Order Drugs.
54. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergiel synchronization technique (BEST) and iridology-study of the iris.
55. For hiring, or the services of, a surrogate mother.
56. For surgical treatment of gynecomastia.
57. For treatment of hyperhidrosis (excessive sweating).

58. For any service for which you are responsible under the terms of this Benefit Booklet to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.
59. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Administrator, on behalf of CEBCO, through Prior Authorization.
60. Complications directly related to a service or treatment that is a non Covered Service under the Plan because it was determined by the Administrator, on behalf of CEBCO, to be Experimental/Investigational or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
61. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that must be covered under federal law with a Prescription.
62. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
63. Treatment of telangiectatic dermal veins (spider veins) by any method.
64. Reconstructive services except as specifically stated in the **Covered Services** section of this Benefit Booklet, or as required by law.
65. For nutritional and dietary supplements, except as provided in the Covered Services section of this Benefit Booklet or as required by law. This exclusion includes, but is not limited to, those supplements that by law do not require either the written prescription of a Physician or dispensing by a licensed pharmacist. It also includes vitamins and food replacements, such as infant formulas and enteral formulas.
66. For room and board charges unless the treatment provided meets the Administrator's Medical Necessity criteria for Inpatient admission for your condition.
67. For supervised living or halfway houses.
68. For services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled or outward bound programs, even if psychotherapy is included.
69. For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.
70. For care received in an emergency room which is not Emergency Care, except as specified in this Benefit Booklet and for anyone over age 15. This includes, but is not limited to suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, dental caries/cavity. For non-Emergency Care please use the closest Network Urgent Care Center and/or your Primary Care Physician for services.

Experimental/Investigative Services Exclusion

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Administrator, on behalf of CEBCO, determines in its sole discretion to be Experimental/Investigative is not covered under the Plan.

The Administrator, on behalf of CEBCO, will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Administrator, on behalf of CEBCO, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Administrator, on behalf of CEBCO. In determining whether a Service is Experimental/Investigative, the Administrator, on behalf of CEBCO, will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Administrator, on behalf of CEBCO to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Administrator, on behalf of CEBCO, has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the BlueCard® PPO Network Hospitals, Physicians and ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the Provider requests a claim form to file a claim, a claim form can be obtained by contacting Your local Human Resources Department or by visiting www.anthem.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 15 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum Allowed Amount

General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the "Inter-Plan Arrangements" section for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established at its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator’s Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan’s non-participating provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator’s Service Area, or a special negotiated price.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider’s charge that exceeds the Plan’s Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket costs to You. Please call Member Services for help in finding a Network Provider or visit the Claims Administrator’s website at www.anthem.com.

Member Services is also available to assist You in determining this Plan’s Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider’s charges to calculate Your Out-of-Pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

Member Cost Share

For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the **Schedule of Benefits** in this Benefit Booklet for Your cost share responsibilities and limitations, or call Member Services to learn how this Plan’s benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by Your Provider for Non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. If services are performed by Out-of-Network Providers, then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount with or without a referral or regardless if allowed as an Authorized Service. Contact the Claims Administrator for more information.

Processing Your Claim

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 15 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

In order to process Your claim, the Claims Administrator may need information from the Provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other Provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your appeals rights and for ERISA plans, information regarding the right to bring an action after the appeals process.

Inter-Plan Arrangements

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area the Claims Administrator serves (the Anthem "Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Anthem Service Area, You will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard[®] Program

Under the BlueCard[®] Program, when You receive Covered Services within the geographic area served by a Host Blue, the Claims Administrator will still fulfill its contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for Your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process Your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard[®] Program

If You receive Covered Services under a Value-Based Program inside a Host Blue’s Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on Your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

E. Nonparticipating Providers Outside the Claims Administrator’s Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem’s Service Area by non-participating providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or Federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network Emergency services.

2. Exceptions

In certain situations, the Plan may use other pricing methods, such as billed charges or the pricing the Plan would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating providers. In these situations, You may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Plan make for the Covered Services as set forth in this paragraph.

F. BlueCard Worldwide[®] Program

If You plan to travel outside the United States, call Member Services to find out Your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification Card with You.

When You are traveling abroad and need medical care, You can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

If You need inpatient hospital care, You or someone on Your behalf, should contact the Claims Administrator for preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

Please refer to the **Health Care Management – Precertification** section in this Booklet for further information. You can learn how to get preauthorization when You need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with BlueCard Worldwide

In most cases, when You arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When You need BlueCard Worldwide claim forms You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

You will find the address for mailing the claim on the form.

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Assignment

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to You. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Member Services Department. Be sure to always give Your Member identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

YOUR RIGHT TO APPEAL

The Administrator's Member Services representatives are trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Coinsurance and Copayment amounts,
- Specific claims or services you have received,
- Doctors or Hospitals in the Network,
- Referral processes or authorizations,
- Provider directories.

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that you may have concerning the Plan. The Plan invites you to share any concerns that you may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in the Administrator's Networks.

The Complaint Procedure

The Plan wants your experience to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. The Administrator will try to resolve your complaint informally by talking to your Provider or reviewing your claim.

Please refer to your Identification Card for the Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Administrator of its' procedures and your benefit document. You may submit your complaint by letter or by telephone call. If your complaint involves issues of Covered Services, you may be asked to sign a release of information form so the Administrator can request records for its' review.

You will be notified of the resolution of your complaint if a claim or request for benefits is denied in whole or in part. The Administrator will explain why benefits were denied and describe your rights under the Appeal Procedure. If you are not satisfied with the resolution of your complaint, you have the right to file an Appeal, which is defined as follows:

Appeal Procedures

As a Member of this Plan you have the right to appeal decisions to deny or limit your health care benefits. The explanation of why the Plan denied your claim or request for benefits will describe the steps you should follow to initiate your appeal and how the appeal process works.

An appeal is a request from you for the Administrator to change a previous determination or to address a concern you have regarding confidentiality or privacy.

Internal Appeals

An initial determination by the Administrator can be appealed for internal review. The Plan will advise you of your rights to appeal to the next level if a denial occurs after an initial determination.

You have the right to designate a representative (e.g. your Physician) to file appeals with the Administrator on your behalf and to represent you in any level of the appeals process. If a representative is seeking an appeal on your behalf, the Administrator must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until the Administrator has received the properly completed DOR form except that if a Physician requests expedited review of an appeal on your behalf, the Physician will be deemed to be your designee for the limited purpose of filing

for expedited review of the appeal without receipt of a signed form. The Administrator will forward a Designation of Representation form to you for completion in all other situations.

The Administrator will accept oral or written comments, documents or other information relating to an appeal from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal. If, after the Administrator's determination that you are appealing, the Administrator considers, relies on or generates any new or additional evidence in connection with your claim, the Administrator will provide you with that new or additional evidence, free of charge. The Administrator will not base its appeal(s) decision(s) on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Administrator fails to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

To obtain information on the Administrator's appeal procedures or to file an oral appeal please call the toll free Member Services number listed on the back of your Plan Identification Card or the number provided for appeals on any written notice of an adverse decision that you receive from the Administrator.

The Administrator will also accept appeals filed in writing. If you wish to file your appeal in writing, you must mail it to: Anthem Blue Cross and Blue Shield, P.O. Box 105568, Atlanta, GA 30348, or to the address provided for filing an appeal on any written notice of an adverse decision that you receive from the Administrator.

Appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, the Administrator will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review your medical records and determine if the service is covered by your benefit document. If the clinical peer determines that the service is covered by your benefit document the Plan must pay for the service; if the clinical peer determines that the service is not covered the Plan may deny the services.

Standard Appeals

If you are appealing an adverse precertification decision other than a retrospective post-claim review decision (i.e., an adverse prospective, concurrent or retrospective pre-claim review decision) or the denial of any prior approval required by the Plan, the Administrator will provide you with a written response indicating the Administrator's decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days of the date the Administrator receives your appeal request. If more information is needed to make a decision on your Appeal, the Administrator will send a written request for the information after receipt of the Appeal. No extensions of time for additional information may be taken on these Appeals without the permission of the Member. Therefore, the Administrator will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the Appeal, the Administrator will provide you with a written response indicating its' decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days from receipt of the Appeal request. If more information is needed to make a decision on your Appeal, the Administrator shall send a written request for the information after receipt of the Appeal. If the additional information requested is not received within 45 calendar days of the Appeal request, the Administrator shall conduct its review based upon the available information.

Expedited Appeals

An expedited appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Given the urgent nature of an expedited appeal, you are encouraged to request an expedited appeal orally. An expedited appeal is available only if the medical care for which coverage is being denied has not yet been rendered. The Administrator will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than seventy-two hours (72 hours) after the Administrator's receipt of the request and will communicate the Administrator's decision by telephone to your attending Physician or the ordering Provider. The Administrator will also provide written notice of the Administrator's determination to you, your attending Physician or ordering Provider, and the facility rendering the service.

You may request an expedited review for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
 1. Could seriously jeopardize your life or health or your ability to regain maximum function, or,
 2. In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care.

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- The Administrator agrees to waive the exhaustion requirement; or
- You did not receive a written decision of the Administrator's internal appeal within the required time frame; or
- The Administrator failed to meet all requirements of the internal appeal process unless the failure:
 1. Was de minimis (minor);
 2. Does not cause or is not likely to cause prejudice or harm to you;
 3. Was for good cause and beyond the Administrator's control;
 4. Is not reflective of a pattern or practice of non-compliance; or
- An expedited external review is sought simultaneously with an expedited internal review.

External Review

Definitions as used in the External Review section include the following:

“Adverse benefit determination” means a decision by a health plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
 - A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;

- A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non employer group, to participate in a plan or health insurance coverage;
- A determination that a health care service is not a covered benefit;
- The imposition of an exclusion, including exclusions source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a health benefit plan.

“Authorized representative” means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

“Covered person” means a subscriber, enrollee, member, or individual covered by a health benefit plan. “Covered person” does include the covered person’s authorized representative with regard to an internal appeal or external review.

“Covered benefits” or **“benefits”** means those health care services to which a covered person is entitled under the terms of a health benefit plan.

“Final adverse benefit determination” means an adverse benefit determination that is upheld at the completion of a health plan issuer’s internal appeals process.

“Health benefit plan” means a benefit plan offered by an Employer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

“Health plan issuer” means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. “Health plan issuer” includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent. The “Health plan issuer” is also called the Administrator in this Benefit Booklet.

“Independent review organization” means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

“Rescission” or **“to rescind”** means a cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

“Stabilize” means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
 - Serious impairment to bodily functions;
 - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

“Superintendent” means the superintendent of insurance.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by the Plan to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer’s internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person’s health benefit plan, and the treating physician certifies at least one of the following:
 - Standard health care services have not been effective in improving the condition of the covered person.
 - Standard health care services are not medically appropriate for the covered person.
 - No available standard health care service covered by the Plan is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The covered person’s treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would

jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.

- The covered person's treating physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person's treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

Note: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external review by the Department in the either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND the Administrator's decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through the Administrator within 180 days of the date of the notice of final adverse benefit determination issued by the Administrator. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however written confirmation of the request must be submitted to the Administrator no later than five (5) days after the initial request. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete the Administrator will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The Administrator will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete the Administrator will inform the covered person in writing and specify what information is needed to make the request complete. If the Administrator determines that the adverse benefit determination is not eligible for external review, the Administrator must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by the Administrator and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When the Administrator initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with the Administrator, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by the Administrator in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by the Administrator of a request for a standard review or within 72 hours of receipt by the Administrator of a request for an expedited review. This notice will be sent to the covered person, the Administrator and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

Note: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on the Plan except to the extent the Administrator has other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law. A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to the Administrator.

If You Have Questions About Your Rights or Need Assistance

You may contact the Administrator:

Anthem Blue Cross and Blue Shield
P.O. Box 105568, Atlanta, GA 30348

To contact the Administrator by phone please call the number on back of your identification card

Fax: **1-888-859-3046**

E-Mail: Ohio.Appeals@anthem.com

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

Appeal Filing Time Limit

The Plan expects that you will use good faith to file an appeal on a timely basis. However, the Administrator will not review an appeal if it is received after 180 days have passed since the incident leading to your appeal.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health Maintenance Organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non group closed panel plans; group-type contracts; medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.
2. Plan does not include: Accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount that is subject to the Primary high-Deductible health plan's Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an Employee, Member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an Employee, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - the Plan covering the custodial parent;
 - the Plan covering the Spouse of the custodial parent;
 - the Plan covering the non-custodial parent; and then
 - the Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1. or 2. above will determine the order of benefits as if those individuals were the parents of the child.
4. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouses plan, Rule 5 applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule in item 1 above to the Dependent child's parent(s) and the Dependent's spouse.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off Employee is the Secondary Plan. The same would hold true if You are a Dependent of an active Employee and You are a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other Federal law and are covered under another Plan, the Plan covering You as an Employee, Member, subscriber or retiree or covering You as a Dependent of an Employee, Member, subscriber or retiree is the Primary Plan and the COBRA or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an Employee or as a retired Employee and is covered under his or her own Plan as an Employee, Member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Dependent of an Employee, Member or subscriber or retired Employee and is covered under the other plan as a Dependent of an Employee, Member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The

Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source.

Recovery

A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
 1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
 2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

GENERAL INFORMATION

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or Employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Circumstances Beyond the Control of the Plan

The Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical, the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the Member Services number on Your Identification Card.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent Employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Medicare Program

When You are eligible for the Medicare program and Medicare is allowed by Federal law to be the primary payer, the benefits described in this Benefit Description will be reduced by the amount of benefits allowed under Medicare for the same Covered Services. This reduction will be made whether or not You actually receive the benefits from Medicare. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

If You Are Under Age 65 With End Stage Renal Disease (ESRD)

If You are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare “three month waiting period” and the additional **30 months** after the Medicare effective date. After 33 months, the benefits described in this Benefit Description will be reduced by the amount that Medicare allows for the same Covered Services.

If You Are Under Age 65 With Other Disability

If You are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This is the case **only** if You are the actively employed Subscriber or the enrolled Spouse or child of the actively employed Subscriber.

If You Are Age 65 or Older

If You are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Description before Medicare. This can be the case only if You are an actively employed Subscriber or the enrolled Spouse of the actively employed Subscriber.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, The Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

Relationship of Parties (Employer-Member-Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

The Employer is fiduciary agent of the Member. The Claims Administrator’s notice to the Employer will constitute effective notice to the Member. It is the Employer’s duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Relationship of Parties (Claims Administrator - Network Providers)

The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Claims Administrator, nor is the Claims Administrator, or any employee of the Claims Administrator, an employee or agent of Network Providers.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Out-of-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or the Claims Administrator.

Community Insurance Company Note

CEBCO, on behalf of itself and its participants, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between CEBCO and Community Insurance Company (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Ohio. The Benefit Booklet is part of a contract solely between CEBCO and Community Insurance Company (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Ohio. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business and/or to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and Federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and Federal laws and the Claims Administrator does not assume any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable Federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, at its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to the Employer.

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group health Plan and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or

supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable appeals procedures.

Governmental Health Care Programs

Under Federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Physicians from various medical specialties including the Claims Administrator's medical directors, Physicians in academic medicine and Physicians in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Payment Innovation Programs

The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by or to the Claims Administrator under the Program(s), and You do not share in any payments made by Network Providers to the Claims Administrator under the Program(s).

Care Coordination

The Plan pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each Covered Service they provide. The Plan may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Plan may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Plan because they did not meet

certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

Program Incentives

The Plan may offer incentives from time to time, at its discretion, in order to introduce You to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, and encouraging You to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. The Plan may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, it is recommended that You consult Your tax advisor.

TERMINATION, CONTINUATION, AND CONVERSION

Termination

It is the responsibility of CEBCO to notify you of the termination of the Plan.

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on CEBCO's agreement with the Plan and your specific circumstances, such as whether fees have been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which the Plan received your notice of termination.
- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Benefit Booklet, your coverage generally will terminate on the last day of the billing period. You must notify CEBCO immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fees paid for such services.
- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by the Plan that the person no longer meets the definition of Dependent.
- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you elect coverage under another carrier's health benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with CEBCO as an option instead of this Plan, then coverage for you and your Dependents will generally terminate at the end of the billing period for which premium has been paid, subject to the consent of CEBCO. CEBCO agrees to immediately notify the Plan that you have elected coverage elsewhere.
- If you fail to pay or fail to make satisfactory arrangements to pay any amount due to the Plan or Network Providers (including the failure to pay required Deductibles, and/or Copayments or Coinsurance), the Plan may terminate your coverage and may also terminate the coverage of all your Dependents, generally effective immediately upon the Plan's written notice to CEBCO.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon the Plan's written notice to CEBCO. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

Federal Continuation of Coverage (COBRA)

Subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, the Plan provides that each of the qualified beneficiaries listed below has the right to choose continuation coverage if his or her coverage under the Benefit Booklet would otherwise end. The election period lasts for 60 days and begins to run on the later of

1. the date that you would lose coverage due to the qualifying event; or
2. the date you are sent notice of your right to continuation coverage.

Unless the election specifies otherwise, an election by a covered Subscriber or a spouse is also considered an election on behalf of any other qualified beneficiary who would also lose coverage due to that qualifying event.

Election Period for Workers who are Receiving Trade Adjustment Assistance

An additional COBRA election period is available for certain eligible workers who have not already elected COBRA. This second election period applies to individuals who have petitions on file requesting certification for trade adjustment assistance under the 1974 Trade Act on or after November 4, 2002.

You are eligible to elect COBRA during this second election period if you:

1. are receiving trade adjustment assistance, as demonstrated by appropriate government certification;
2. lost group health plan coverage due to a job loss that resulted in eligibility for trade adjustment assistance; and
3. failed to elect COBRA during the regular COBRA election period that was triggered by that job loss.

This second 60-day COBRA election period begins on the first day of the month in which you are determined to be eligible for trade adjustment assistance, but no election may be made later than six months after the initial loss of group health plan coverage.

Any COBRA coverage elected through this second election period will begin with the first day of the second election period, and not on the day on which you first lost group coverage. However, the time between the initial loss of coverage and the start of the second election period will not count in determining if there is a 63-day break in coverage for purposes of HIPAA.

Qualifying Events and Qualified Beneficiaries

The following qualified beneficiaries (not including nonresident aliens who received no income constituting earned income under federal law from CEBCO and the nonresident aliens' Dependents) have the right to continuation coverage when one of the following qualifying events results in a loss of coverage under the contract:

1. Upon the death of the covered Subscriber: the spouse and the Dependent children.
2. Upon the covered Subscriber's termination (for other than gross misconduct) or reduction in work hours; the Subscriber and his or her eligible Dependents.
3. Upon divorce or legal separation of the covered Subscriber: the divorced or legally separated spouse and Dependent children.
4. Upon the covered Subscriber becoming enrolled in Medicare under Title XVIII of the Social Security Act: the spouse and Dependent children.
5. Upon the disqualification of a Dependent child under the Benefit Booklet's eligibility requirements: the Dependent child not meeting such requirements.
6. Upon CEBCO's filing of a Title XI Bankruptcy: the retired covered Subscriber and his or her Dependents who (a) as a result of the bankruptcy filing would experience a substantial elimination of

health coverage, under the Benefit Booklet, within a year of the bankruptcy filing; or (b) has experienced an elimination of coverage during the year preceding the bankruptcy filing

For the purpose of this section, coverage for a Dependent child includes coverage for any child born to or placed for adoption with a qualified beneficiary after a qualifying event if proper notice is provided to CEBCO of the birth or adoption.

If you have already enrolled in Medicare before the time of your qualifying event, you may still elect COBRA coverage. If you enroll in Medicare after you have already elected COBRA coverage, then your COBRA coverage will terminate as stated below in number 4, Cancellation.

If a Spouse or Dependent Child of a Subscriber is covered through a Subscriber by alternative coverage, and the right to receive the alternative coverage will cease upon the death of or divorce or legal separation from the Subscriber, the end of the alternative coverage shall be considered a qualifying event as described in 1 and 3 above, regardless of whether the alternative coverage would satisfy COBRA continuation coverage rules. "Alternative coverage" means coverage provided by an employer without regard to COBRA continuation coverage, as a result of: state or local law; industry practice; a collective bargaining or severance agreement; plan procedure; or disability or workers compensation leave.

Duration of Continuation Coverage

1. For the events explained in paragraphs "1," "3," "4," and "5" under "Qualifying Events and Qualified Beneficiaries," continuation coverage is provided for 36 months after the date of the initial qualifying event.
2. For the event explained in paragraph "2" under "Qualifying Events and Qualified Beneficiaries," continuation coverage is provided for 18 months after the date of the qualifying event.

Exceptions:

- a. If the qualifying event under paragraphs "1," "3," "4," or "5" above occurs during the 18-month period, continuation coverage will be continued an additional 18 months; or
- b. If a qualified beneficiary is determined under Titles II or XVI of the Social Security Act to be disabled at any time prior to or during the first 60 days of continuation coverage under paragraph "2," under "Qualifying Events and Qualified Beneficiaries," continuation coverage will be extended an additional 11 months.

However, coverage will be extended only if the qualified beneficiary gives notice of the disability within 60 days after the disability is determined and before the end of the original 18-month continuation period. When the qualified beneficiary is no longer disabled, he or she must notify CEBCO within 30 days after the final determination is made under Titles II and XVI.

- c. If the Subscriber became enrolled in Medicare prior to the qualifying event, the period of coverage for qualified beneficiaries other than the Subscriber shall be the longer of 18 months from the termination or reduction in hours of employment or 36 months from the earlier Medicare entitlement.
3. For the event explained in paragraph "6" above, continuation coverage is provided until the death of the retired covered Subscriber. If the covered Subscriber dies before the occurrence of the qualifying event, continuation coverage is provided until the death of the surviving spouse. Upon the death of the covered Subscriber, his or her Dependents (other than a surviving spouse entitled to lifetime coverage) are entitled to continuation coverage as explained in paragraph "1" of the preceding section.

The maximum period for all qualifying events is 36 months, except as may occur under paragraph "3" immediately above.

Fees

You must pay fees for any period of continuation coverage. If you make the election after the qualifying event, any fees due must be paid by 45 days after the date of the election.

Cancellation

Continuation coverage will terminate if:

1. CEBCO ceases to provide any group health Plan to its Members;
2. fees are not paid on time;
3. upon the date, after the date of continuation coverage election, a qualified beneficiary other than beneficiaries that are provided continuation of coverage under paragraph "6," under "Qualifying Events and Qualified Beneficiaries," first becomes enrolled in Medicare benefits under Title XVIII of the Social Security Act; or
4. a qualified beneficiary who was disabled under paragraph "2" under "Qualifying Events and Qualified Beneficiaries," is no longer disabled. The additional 11 months of extended continuation coverage will be terminated on the first day of the month that begins more than 30 days after the date of the final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled.

Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Family and Medical Leave Act

Subject to the requirements of the Family and Medical Leave Act (FMLA) as amended, any Subscriber entitled to FMLA leave may continue their benefits, and any Dependents' benefits, under the Plan as if continuously employed during the entire FMLA leave period. Certain limitations stated below may apply. No new conditions or waiting periods will apply to the benefits upon your return to work.

You may be entitled to FMLA leave for the following reasons:

- Birth of a child, and to care for such child;
- Placement of a child with you for adoption or foster care;
- To care for your seriously ill spouse, child, or parent;
- A serious health condition that makes you unable to perform your job functions.

CEBCO is responsible for determination of your eligibility, rights, or length of leave period for FMLA for purposes of continuing your benefits under the Plan.

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1984, as amended.

“Military service” means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying CEBCO in advance and payment of any required contribution for health coverage. This may include the amount CEBCO normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under the Plan shall be the lesser of:

The 24-month period beginning on the first date of your absence from work; or
The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under the Plan. No Exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

DEFINITIONS

Accidental Injury

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

Ambulance Services

A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Authorized Service(s)

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the **Claims Payment** section.

Behavioral Health Care

Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Benefit Period

One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Centers of Excellence (COE) Network

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Anthem Insurance Companies, Inc. was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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Coinsurance

If a Member's coverage is limited to a certain percentage, for example 85%, then the remaining 15% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

Combined Limit

The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

Complications of Pregnancy

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment

A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **Schedule of Benefits** for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the Provider when services are rendered.

Cosmetic Surgery

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

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Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the **Eligibility** section of this Benefit Booklet, has enrolled in the Plan, and is subject to administrative service fee requirements set forth by the Plan.

Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services. It usually is applied on a calendar year basis.

Dependent

The Spouse and all children until attaining age limit stated in the **Eligibility** section. Children include natural children, legally adopted children, foster children that live with the Employee and for whom the Employee is the primary source of financial support, and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally, intellectually or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

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Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Emergency Medical Condition

(“Emergency services,” “emergency care,” or “Medical Emergency”) Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

Formulary

A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to (1) a listing of preferred Prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Members through pharmacies that are Network Providers, and (2) Precertification rules. This list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

Freestanding Ambulatory Facility

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed by the appropriate agency. A Physician’s office does not qualify as a Freestanding Ambulatory Facility.

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Group Health Plan or Plan

An employee welfare benefit plan (as defined in Section 3(1) of ERISA), established by the Employer, in effect as of the Effective Date.

Home Health Care

Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency

A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate agency.

Hospice

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

Identification Card

The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

Ineligible Charges

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

Ineligible Provider

A Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

Infertile or Infertility

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee

A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury

Bodily harm from a non-occupational accident.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit

A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Intensive Outpatient Programs

Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Late Enrollees

Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

Maternity Care

Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Allowed Amount

The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the **Claims Payment** section.

Medical Facility

A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit Booklet. The facility must be licensed, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Medical Necessity or Medically Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or Injury and that is determined by the Claims Administrator to be:

- medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or Injury;
- obtained from a Provider;
- provided in accordance with applicable medical and/or professional standards;
- known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- the most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, Injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- not Experimental/Investigative;
- not primarily for the convenience of the Member, the Member's family or the Provider; or,
- not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Member

Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

Network Provider

A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

New Hire

A person who is not employed by the Employer on the original Effective Date of the Plan.

Non-Covered Services

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Out-of-Network Provider

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

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Out-of-Pocket Maximum

The maximum amount of a Member's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

Partial Hospitalization Program

Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. **The Plan Administrator is not the Claims Administrator.**

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. **The Plan Sponsor is not the Claims Administrator.**

Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

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Primary Care Physician

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of Your Identification Card.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan Member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

Residential Treatment Center/Facility

A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured Facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care

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- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Semiprivate Room

A Hospital room which contains two or more beds.

Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient’s home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Specialist (Specialty Care Physician\Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Spouse

For the purpose of this Plan, a Spouse is defined as shown in the **Eligibility** section of this Benefit Booklet.

Therapeutic Equivalent

Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

Transplant Providers

Network Transplant Provider - A Provider that has been designated as a “Center of Excellence” for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a “Center of Excellence” for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

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Urgent Care

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, procedures, and/or facilities.

You and Your

Refer to the Subscriber, Member and each Covered Dependent.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.anthem.com.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under Federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the **Schedule of Benefits**.

If You would like more information on WHCRA benefits, call Your Plan Administrator.

Coverage for a Child Due to a Qualified Medical Support Order (“QMCSO”)

If You or Your Spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask Your Employer or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out-of-pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out-of-pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request

Special Enrollment Notice

If You are declining enrollment for yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, if You or Your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards You or Your Dependents' other coverage). However, You must request enrollment within 31 days after You or Your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and Your Dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Member Services telephone number on Your Identification Card or contact Your Plan Administrator.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Company (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on Your Identification Card for help (TTY/TDD: 711). If You think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, You can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in Your language for free. Call the Member Services number on Your Identification Card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of Your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic

ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD: 711).

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa

Ḑ bédé dyí-bèdèìn-dèè b'é m' k'é b' n' à k'e k'e gbo-kpá- kpá dyé dé m' bídí-wùdùùn b'ó pídyi. Ḑá mébà jè gbo-gmò Kpòè n'òbà n' à n' Dyí-dyoìn-b'èṣ k'ṣe b'é m' k'é gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka

Yin nɔŋ yic ba ye lək nē yök ku bē yi kuony nē thōŋ yin jām ke cin wëu töu kē piiny. Col rän töŋ dē koc kē luoi nē nämba dën tö nē I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati

તમે તમારી ભાષામાં મદદ માંગી શકો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntwam koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo

Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadi NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ នឹងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលេខប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi

Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Laṛ

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງພວກເຮົາ ຫຼື ການສະມາຊິກທ່ານໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo

Bee ná ahoot'í' t'áá ni nizaad k'ehjí níká á a'doowol t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néé'ho'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néé'ho'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíílnih. (TTY/TDD: 711)

Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्न तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch

Du hoscht die Recht selle Information un Hilfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Hilfe aa. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian

Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apălați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan

E iai lou 'aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totoi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian

Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)۔

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish

רופט די איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
מעמבער באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba

O ní ẹ̀tọ́ láti gba ìwífún yíí kí o sì ẹ̀rànwọ́ ní èdè rẹ̀ lófẹ́ẹ̀. Pe Nọmbà àwọn ìpèsè ọmọ-ẹgbẹ̀ lórí káàdì ìdánimọ̀ rẹ̀ fún ìrànwọ̀. (TTY/TDD: 711)